

Marine Cargo Claim Form

The supply or acceptance of this form is not an admission of liability on the part of Allianz Marine & Transit Underwriting Agency.

To assist us to quickly process your claim please include (where applicable) the following documents:

- Copy of consignment note/ bill of lading/ delivery note including terms and conditions on reverse
- Copy of letter of demand sent to the carrier/ shipper
- Repair quote if goods are repairable
- Copy of commercial invoice for goods while in transit
- Packing slip
- Pictures of the damage

Once completed this form and attachments can either be scanned and sent by email to marine@allianz.com.au or posted to the address shown below.

Insured's Details

Name of insured _____

Contact person _____

Telephone no. Home () _____ Work () _____ Mobile no. _____

Email _____

Postal address _____
 _____ State _____ Postcode _____

Policy no. _____

Should a survey be required, our appointed surveyor will contact the person shown above, unless you advise an alternative contact.

GST

Are you registered for GST purposes? Yes No

ABN _____

Are you entitled to claim an input tax credit for repair or replacement of the items that have been lost or damaged? Yes No

Will you be claiming less than 100%? Yes No

If No, what percentage _____ %

Settlement Details

Where applicable Allianz Marine & Transit Underwriting Agency will settle directly in your bank account once the liability for this claim is agreed.

Please provide your banking details

Bank _____

BSB _____

Account name _____

Account no. _____

If you require settlement by cheque please tick here

Transit Details

Name of carrier _____

Mode of transport _____

Date of despatch ____ / ____ / ____ Date of arrival ____ / ____ / ____

Voyage from _____ Voyage to _____

Consignee name _____

Address _____
 _____ State _____ Postcode _____

Cargo Loss Details

Date of incident ____ / ____ / ____

State in detail the nature of the loss/destruction/damage _____

Goods Lost/Damaged/Stolen or Destroyed (if insufficient space, please attach separate list)

List of Goods Lost/Damaged/Stolen or Destroyed	Amount Claimed
	\$
	\$
	\$
	\$
	\$
	\$

How were the goods packed or protected? _____

Where can the goods be inspected? _____

Please confirm that you have written to the shipping company/carrier holding them responsible for the loss (Kindly attach copy of this correspondence)

Yes

No

Privacy Notice

The personal and sensitive information collected in this form and other information you or third parties provide in connection with this claim will be used to process this claim, compile and analyse data, and resolve claim disputes. If you do not provide this information to us we may not be able to process this claim.

We may have to disclose your personal and other information to third parties who assist us in assessing and processing this claim, including other insurers, health service providers, investigators, our specialist advisors, our service providers or as required by law.

You have the right to seek access to your personal information and to correct it at any time. For information about how you may access and request correction of personal information we hold about you, or complain about a breach of the Australian Privacy Principles, please see our privacy policy available at www.allianz.com.au or contact us on 1300 360 529 EST 9am-5pm, Monday to Friday.

Declaration

I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed. I/We acknowledge that I/we have read and understood the privacy information referred to above and consent to the collection, storage, use and disclosure of personal and sensitive information of all persons affected by this claim, with their approval. I/We acknowledge that if I/we do not agree to the collection of this personal and sensitive information then Allianz will be unable to process my/our claim.

Signature of Insured _____ Date ____ / ____ / ____

Position _____